ACT Health

# RESULTS FROM THE AUSTRALIAN CAPITAL TERRITORY (ACT) NURSE PRACTITIONER WORKFORCE AND EMPLOYER SURVEY

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## AUTHOR

Christopher J. Helms

Senior Project Adviser, ACT Health Directorate, Office of Professional Leadership and Education

## AUTHOR NOTE

The results from this survey satisfy Project Deliverable 1.1.4 of the Nurse Practitioner Practice Project, which was sponsored by the Australian Capital Territory (ACT) Office of the Chief Nursing and Midwifery Officer. This survey, along with an outcome evaluation will inform a broader consultation document used for internal and external consultation.

## ACKNOWLEDGEMENT OF COUNTRY

ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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# Background

This paper presents the results of a workforce survey conducted with nurse practitioners (NP) and their employers in the Australian Capital Territory (ACT). It was completed as part of the ACT Nurse Practitioner Practice Project (NP-PP). The NP-PP was led by the ACT Office of the Chief Nursing Officer at the request of the ACT Minister for Health, Rachel Stephen Smith, MLA.

Nurse practitioners are registered nurses (RN) whose practice is regulated by the Nursing and Midwifery Board of Australia (NMBA) through a rigorous endorsement process (Nursing and Midwifery Board of Australia, 2020c). They practice independently and collaboratively in an expanded clinical role (Nursing and Midwifery Board of Australia, 2020a). That expanded role includes common core activities in which they receive extensive postgraduate education and training, including: advanced assessment and diagnostic capabilities, prescribing medicines, requesting and interpreting diagnostic examinations, and independently referring to medical and allied health practitioners (Australian Nursing and Midwifery Accreditation Council, 2015).

The nursing profession achieved legislated title protection for the NP role in 2000 (Foster, 2010). Australian NPs work in every jurisdiction, across both the public and private health sectors, in over 50 different areas of specialty practice (Helms et al., 2017a). Currently there are over 2100 NPs holding NMBA endorsement, 54 of which declare their principal place of practice as being the ACT (Nursing and Midwifery Board of Australia, 2020b).

The NP-PP aims to better understand the current ACT NP workforce, their requirements, and the legislative and policy barriers that potentially preclude them from achieving full practice authority in the ACT. Information gained from this survey will be used to inform a broader consultation strategy aiming to explore solutions to legislative and policy burdens affecting NP clinical practice in the ACT.

This survey represents a scoping exercise whose intent is to provide insight into the current state of the ACT NP workforce and whether the aims and intended outcomes of the NP-PP are appropriate.

# Methods

An online survey was conducted. The aim of the study was to gain information relating to:

- current NP workforce characteristics and practice profiles
- how employers use and perceive the NP workforce
- barriers and facilitators to NP practice in the ACT

Inclusion criteria for survey participants were:

- working within the ACT or surrounds, and
- NMBA-endorsed NP, or
- student enrolled in an NP academic program, or
- NP employer/manager

Recruitment for the survey occurred between 20 November and 23 December 2020. A combination of convenience and snowball sampling was used. An email providing information about the survey was sent to a list comprising public and private sector NP employers in the ACT, as well as through a database of NPs practising within the ACT maintained by the Australian College of Nurse Practitioners (ACNP). The ACNP report their membership represents 50% of the Australian NP workforce (Boase, 2020). According to the NMBA there are currently 2,100 NPs practicing in Australia, with 54 declaring the ACT as their principal place of practice (Nursing and Midwifery Board of Australia, 2020b). Email recipients were asked to forward a copy of the email to those who they thought might be eligible or interested in taking the survey. A copy of the invitation email can be found at Appendix B. Finally, a reminder email was sent to the list of employers and NPs three days prior to closing of the survey.

Potential participants were screened for eligibility at the beginning of the survey through adaptive survey questioning. Those respondents who provided responses indicating they did not meet the above inclusion criteria were screened and excluded from further participation by re-directing them to the end of the online survey. Those respondents were thanked for their interest, provided with contact details if they had any questions or concerns, and excluded from further data analysis.

The Survey Monkey platform was used as an online survey tool. Questions were designed to obtain a mixture of dichotomous, (e.g., yes/no, public/private, etc.) categorical (e.g., NP, employer, student, etc.), and scale-level data (e.g., years practising as an NP). Questions were primarily presented as a mix of multiple choice and Likert scale responses. Additional open-ended questions with open text boxes were provided to elicit further detail from survey participants in relevant areas where the supplied options did not fit their individual circumstances. At the end of the survey participants were invited to provide their contact details if they would like to provide further detail or feedback on the survey to ensure their views were adequately represented.

A pragmatic approach was used to develop survey questions relevant to the aims of the survey. Questions were included from validated Australian nursing workforce surveys (Health Workforce Australia, 2012), NP toolkits derived from Australian research (Gardner et al., 2009), and

organisational climate surveys specifically focussed on understanding the NP experience when working within a larger organisation (Poghosyan et al., 2013; Scanlon et al., 2018).

The survey was presented as a single online tool but used “adaptive questioning” to provide three different survey experiences for participants (Helms et al., 2017). This meant the total survey length was 70 questions, but its true length was much shorter and was dependent upon participant responses. If a participant responded to a single question in one manner, whereas another respondent provided a response to the same question in an alternative manner, divergent subsequent questions would be presented depending on a respondent’s initial response. Thus, the survey length ranged anywhere from two questions (at its shortest) to 40 questions (at its longest) for participants. Most of the questions were mandatory and required a response in order to proceed to subsequent pages of the survey. A copy of the survey can be found at Appendix A.

The survey was piloted amongst a group of health service administrators, policy officers, nurse practitioners, and the ACT Chief Nursing and Midwifery Officer (CNMO) project management team. Relevant feedback included a request to shorten the survey and consolidate where possible, use contextual Australian terminology where relevant, improve flow of presented questions, and provide greater clarity of intent with certain questions through simplification of sentence structure.

Quantitative data were analysed using simple descriptive statistics. Qualitative data arising from open text boxes underwent summative content analysis (Hsieh & Shannon, 2005). Comparisons of proportionality were made between NPs and employers/managers, as well as public vs private sector NPs due to the expected low sample size. Participants who indicated they wanted to be interviewed were allocated a one-hour timeslot via Webex using a semi-structured interview format. See Appendix C for a list of interview questions. Responses to these questions were recorded and again underwent summative content analysis, to provide richer insight into the presented quantitative data.

# Results

A total of 32 persons responded to the survey invitation email, with two persons excluded from the survey, as they reported they did not work in the ACT or surrounds or were not an NP or NP employer/manager. There was a total of 30 eligible participants with an 81% overall survey completion rate; two of the 26 eligible NPs did not complete the survey. This means that, based on NMBA data, approximately 44% (n=24/55) of the eligible population of ACT NPs participated in this survey (Nursing and Midwifery Board of Australia, 2020b). Participants took an average of 10 minutes to complete the survey.

Of those eligible to take the survey, 87% (n=26/30) stated they were NMBA-endorsed NPs and 13% (n=4/30) stated they were an NP employer or manager. No students enrolled in an NP program participated in the survey. Of eligible participants, 50% (n=13/26) of NPs and 25% (n=1/4) of NP managers/employers indicated they would like to be interviewed after completion of the survey.

# Nurse Practitioner Responses

Of the NPs completing the survey, 96% (n=23/24) described their current role as a clinician, with one describing their role as a teacher or educator. When asked about their work setting, 75% (n=18/24) described settings in the primary healthcare sector, including walk-in centres (WiCs), general practices, community health services, independent private practices, and aged care. The remaining 20% (n=5/24) worked in inpatient and/or outpatient hospital settings or in the tertiary education setting (4%; n=1/24). Most (71%; n=17/24) of the ACT NP workforce work in the public sector.

When asked about the metaspecialtie(s) (Gardner et al., 2019) that were most representative of their clinical practice, 63% (n=15/24) stated primary healthcare, followed by ageing and palliative care (38%; n=9/24), chronic and complex care (38%; n=9/24), mental health care (25%; n=6/24), emergency and acute care (17%; n=4/24), and child and family health care (8%; n=2/24). Participants had the option of providing the area of practice in which they worked through an open text box. Specific areas listed by NP respondents can be found in *Table 1* below:

*Table 1: Specific areas of practice of nurse practitioner respondents*

| Specialty Area | Number |
|---|---|
| *Sexual and Reproductive Health* | 4 |
| Oncology/Haematology Care | 2 |
| Palliative Care | 4 |
| *Wound Management* | 1 |
| *Alcohol and Other Drugs* | 1 |
| Gerontic Health | 7 |
| Primary Healthcare | 5 |
| *Cardiac Care* | 1 |
| **NOTE:** Some participants listed more than one area of practice, and specialty areas have been grouped into the formal Australian nursing specialties and *practice strands* (King et al., 2010). | |

Forty-two percent (n=10/24) of NP respondents had been endorsed for 0-5 years, followed by an additional 42% (n=10/24) having been endorsed for 6-11 years. Four of the NP respondents (17%) had been endorsed for 12+ years. Of those participants who had been endorsed for more than 5 years, 29% (n=4/14) stated they intended to remain within the nursing workforce for an addition 1-5 more years before retirement. All (n=5) NPs working in the private sector indicated they intend to work in nursing for 6 or more years, and 76% (n=13/18) of public sector NPs indicated they would remain in the nursing workforce for the same period of time.

Few NP respondents (n=3) stated they were currently working in a clinical role not requiring them to be an NP. Responses about the reason this might be were: actively working on a project to expand their current clinical role (n=1), providing contractual consultancy services (n=1), or had family obligations (n=1) precluding them from obtaining an NP role.

Most NP respondents that stated they were currently employed in a role requiring them to be an NP were working full-time (77%; n=17/22), and 95% of those (n=21/22) stated "clinician" best described their role. One participant stated their role was best described as a "teacher or educator."

Nurse practitioner respondents were asked about their organisational climate during the survey. A comparison of responses between public and private sector NPs is provided in *Table 2* as weighted averages. Weighted averages were calculated from participant's ratings on a 5-point Likert scale (Strongly Disagree [1] – Strongly Agree [5]) to better compare between the private and public sectors:

*Table 2: Nurse practitioners' perceptions of their organisational climate according to health sector*

| Statement | **Public Sector** (n=17) | **Private Sector** (n=5) |
|---|---|---|
| | **Weighted Ave.** (Max 5) | **Weighted Ave.** (Max 5) |
| The organisation makes efforts to improve working conditions for NPs. | **2.53** | **4.60** |
| Doctors and NPs have similar support for care management. | **2.59** | **4.40** |
| In my organisation, there is constant communication between NPs and the executive team. | **2.65** | **4.40** |
| The organisation shares information and resources equally with NPs and doctors | **2.71** | **4.20** |
| I regularly get feedback about my performance from my organisation. | **2.76** | **4.60** |
| In my organisation, the NP role is well understood. | 3.00 | 4.40 |
| I feel valued by my organisation. | **3.00** | **5.00** |
| My organisation inappropriately restricts my abilities to practice within my scope of practice. | **3.00** | **1.20** |
| Doctors seek NPs' advice and input when providing patient care. | 3.18 | 3.60 |
| My manager is well-informed of the skills and competencies of NPs. | 3.29 | 4.40 |
| My manager takes NP concerns seriously. | **3.59** | **4.80** |
| Doctors in my practice setting trust and support my patient care decisions. | 3.65 | 4.40 |
| The organisation is open to NP ideas to improve patient care. | **3.71** | **4.80** |
| My organisation creates an environment where I can practice independently and collaboratively. | **3.76** | **4.80** |
| I feel valued by my medical colleagues. | 3.88 | 3.80 |
| NPs are an integral part of the organisation. | **3.88** | **5.00** |
| In my organisation, I freely apply all my knowledge and skills to provide patient care. | 4.00 | 4.80 |
| In my practice setting, I have colleagues who I can ask for help. | **4.24** | **4.80** |
| I do not have to discuss every patient care detail with a doctor. | 4.71 | 4.80 |
| **NOTE:** Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result. | | |

In addition, NP respondents were asked about the tools and resources required to do their work safely, effectively and efficiently. They ranked the importance of the following tools and resources according to a 4-point Likert scale (Not Important [1] – Very Important [4]). Again, weighted averages between public and private sector NPs are provided for comparison purposes in *Table 3* below:

*Table 2: Importance of tools and resources to nurse practitioner practice*

| **How important are the following tools and resources?** | **Public Sector (n=17)** | **Private Sector (n=5)** |
|---|---|---|
| | **Weighted Ave.** (Max 4) | **Weighted Ave.** (Max 4) |
| Access to online patient support databases. | 3.88 | 4.00 |
| Access to prescribing support software. | 3.82 | 4.00 |
| Prescribe subsidised medicines. | 3.65 | 4.00 |
| Access to peer review of patient care. | 3.65 | 4.00 |
| Access to mentorship. | 3.59 | 3.75 |
| Request subsidised diagnostic imaging. | 3.53 | 4.00 |
| Request subsidised allied health review. | 3.47 | 4.00 |
| Clinical documentation and support software. | 3.47 | 4.00 |
| Request subsidised diagnostic pathology. | 3.41 | 4.00 |
| Access to portable technology (e.g. mobile phones, laptops) | 3.41 | 3.25 |
| Clerical support. | 3.29 | 3.50 |
| Request subsidised medical specialist review. | 3.20 | 4.00 |
| Access to the Australian Immunisation Handbook. | 3.18 | 4.00 |
| Access to the My Health Record. | 2.82 | 3.75 |
| Access to the Australian Immunisation Register. | 2.82 | 3.75 |
| Ability to sign advance care directives. | 2.59 | 3.25 |
| Ability to sign worker's compensation certificates. | 2.25 | 1.75 |
| Hospital admission privileges. | **2.06** | **1.00** |
| Hospital visitation privileges. | 2.00 | 1.75 |
| Ability to sign death certificates. | 2.00 | 2.25 |
| Ability to sign driver's license medicals. | 2.00 | 2.50 |
| Hospital discharge privileges. | 1.82 | 1.00 |

**NOTE:** Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result.

To delve further into the importance of the above tools, NP participants were asked if they were able to perform core activities of the NP role to the fullest extent of their individual scopes of practice. The following tools have traditionally defined the expanded role of the NP, namely:

- prescribing medicines
- requesting diagnostic pathology
- requesting diagnostic imaging
- referral to medical specialists
- referral to allied health specialists

Participants rated their ability to perform the stated tasks to their full scope of practice on a 4-point Likert scale (Not at All [1] – Yes, Absolutely [4]). Again, NP participants are compared between public and private sectors using weighted averages, as per the results outlined in *Table 4* below:

*Table 3: Ability of nurse practitioners to perform core scope of practice activities*

| **Are you able to perform the following to your full scope of practice?** | **Public Sector** (n=17) | **Private Sector** (n=5) |
|---|---|---|
| | **Weighted Ave.** (Max 4) | **Weighted Ave.** (Max 4) |
| Prescribe medicines | 3.00 | 3.75 |
| Refer to allied health specialists | 2.41 | 2.50 |
| Request diagnostic pathology | 2.24 | 3.00 |
| Refer to medical specialists | **2.12** | **3.25** |
| Request diagnostic imaging | 1.82 | 1.75 |
| **NOTE:** Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result. | | |

Clinical efficiency is defined as a clinical outcome divided by time (Usherwood, 1987). Participants were advised this includes the time to assess, diagnose and treat a health condition, but also includes time taken for administrative processes that result in care outcomes. Clinical efficiency would include documenting care, filling out forms, requesting screening and diagnostic testing, prescribing, and referring to other health professionals.

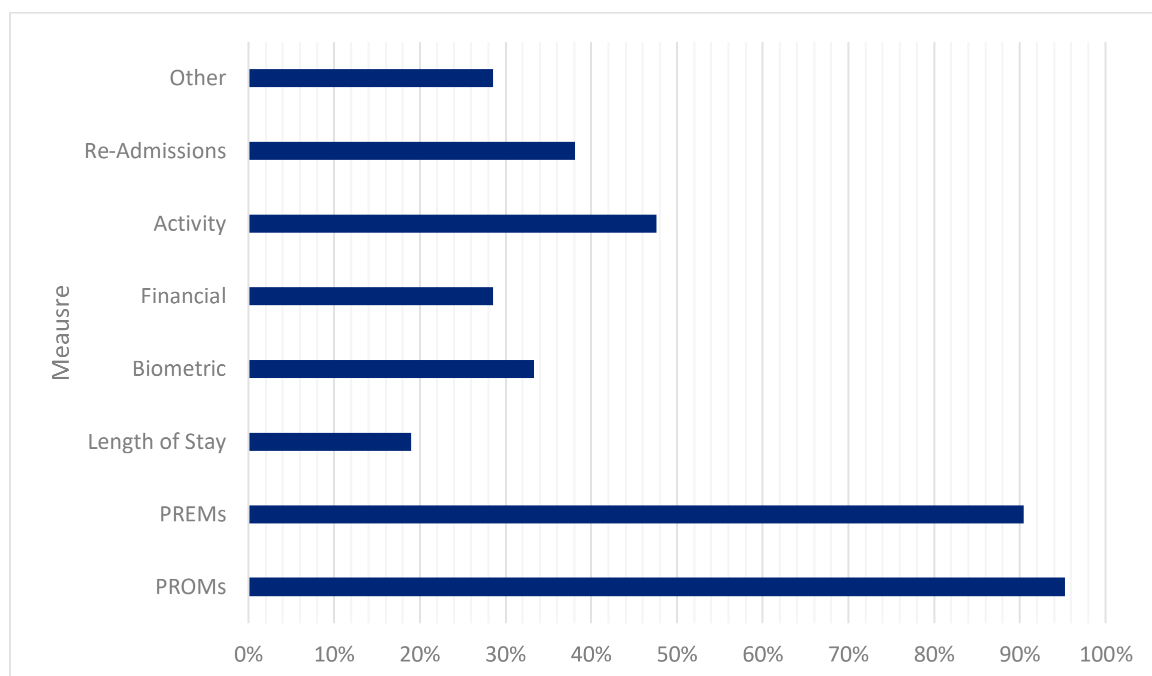
Nurse practitioner participants were asked whether they had all the tools and resources they require for clinically efficient care. Participants rated this statement on a 4-point Likert scale (Not at All [1] – Yes, Absolutely [4]). Again, NP participants are compared between public and private sectors using weighted averages, as per the results outlined in *Table 5*.

*Table 4: Clinical efficiency perceived by nurse practitioners*

| | **Public Sector** (n=17) | **Private Sector** (n=5) |
|---|---|---|
| | **Weighted Ave.** (Max 4) | **Weighted Ave.** (Max 4) |
| Do you have all the tools and resources you require for clinically efficient care? | 2.82 | 3.50 |

Finally, NP participants were asked about the outcomes of NP-directed care and the different ways to measure and identify success, or areas for improvement in care provision. Participants were asked what measures they believed were helpful in identifying the "value-add" of NP clinical practice. Most respondents identified patient-reported outcomes measures [PROMs] (95%; n=20/24) and patient-reported experience measures [PREMs] (91%; n=19/24) as being helpful. Participant responses are shown in *Figure 1* below:

*Figure 1: Outcomes measures that nurse practitioners believe are helpful*




Participants provided additional insight and measures into this question in the 'other' field. Responses included:

- appropriateness of consultation referrals initiated by NPs
- consultations performed upon request from other health professionals
- intervention delay (e.g. dialysis start) and associated cost savings
- family and staff feedback on performance
- decreased emergency department presentations

Nurse practitioner participants were asked if the measures they identified were monitored and reported by their health services. Participants responded to this statement on a 5-point Likert scale (Never [1] – Always [5]). Again, NP participants were compared between public and private sectors using weighted averages, as per the results outlined in *Table 6* below:

*Table 5: Monitoring of outcomes measures in healthcare*

| | **Public Sector** (n=17) | **Private Sector** (n=5) |
|---|---|---|
| | **Weighted Ave.** (Max 4) | **Weighted Ave.** (Max 4) |
| Are the measures you've identified monitored and reported by your health service? | 2.65 | 1.67 |

At the end of the survey, NP participants were asked if they had any additional comments. These are summarised below:

- Some questions relating to organisational climate were not applicable to the work setting, as the respondent worked in a nursing-only health service.
- Responses to scope of practice questions were relevant to the position and health service in which the respondent was currently working, and not reflective of their full scope of practice.
- Some roles did not require access to diagnostic examinations or referral to specialists.
- Ability to achieve full scope of practice differs between inpatient and outpatient settings.
- Survey was not reflective of the advanced role of the NP outside the clinical environment, such as serving on national committees and strategic groups.
- Health services are monitoring admissions and numbers of visits, but this does not accurately represent the care NPs provide.

## Nurse Practitioner Interviews

At the end of each survey NP participants were asked if they would like to be interviewed to further discuss their responses. Thirteen NP respondents indicated they wanted to be interviewed upon completion of the survey, with eight proceeding to the interview stage. Written notes were recorded during each interview, with results summarised in this section.

Overall, participants reported that the survey was representative of their views. A minority of interviewees advised they felt the survey was orientated towards the public sector, or larger health services involving multidisciplinary care teams. Those views were primarily held by NPs working as sole providers or in nurse-led clinics. One NP interviewee was unsure how to respond to certain questions as they held two clinical NP roles within the public sector.

Participants requesting to be interviewed were then advised on the aims of the NP-PP in achieving "right touch" legislation and policy to enable NP practice. They were asked about any barriers they

experience in their practice. In addition, they were specifically requested to comment on the unintended consequences of facilitating the ability of NPs in the ACT to authorise/perform:

- death certificates and advance care directives
- worker's compensation and Comcare certificates
- driver's license medicals
- medical terminations of pregnancy

When providing their responses, respondents were also asked what frameworks, education or support would be required for a NP working within their scope of practice to authorise or perform the above activities.

All respondents were supportive of an NP working within their scope of practice to be authorised to perform the above activities in the ACT. None could identify any unintended consequences of legislative or policy reform that would allow these activities, although some participants voiced concern that worker's compensation could be complicated and require long-term follow up. They also voiced the observation that worker's compensation cases are viewed through a different clinical and medico-legal lens than your average clinical case, and that this requires consideration when providing education and training to fulfill the required practice activity. They also suggested the type of patient and presenting condition arising from a work-related incident would need to be considered in the context of the model of care or NP practice context in order to properly oversee the care of the patient.

Participants shared several stories of their long-term patients who had died in the community, who lay in state for days at home while waiting for a medical practitioner to sign their death certificate, even though the NP was the patient's primary carer and most familiar with their medical history. These issues were not only distressing for families, but for the practitioners themselves.

With relation to advance care directives, some NPs perceived that many medical practitioners did not have the time or expertise to lead such discussions with their patient. Despite the NP initiating and leading advance care directive discussions, a medical practitioner was still required for the witnessing of a non-written health directive, even though in many instances that medical practitioner had no relationship with the patient, did not take part in or lead the discussion, and was unfamiliar with the patient's medical history.

Much of the participant concern cited around death certificates, driver's license medicals, and advance care directives was the fact the long-term relationship shared between the NP and the patient were not accounted for in legislation. Several NPs in both the public and private sectors were either the primary or only provider of care for the patient. The involvement of practitioners outside the patient's preferred care team for the purposes of satisfying legislative requirements for the above activities was seen as a breach of trust and privacy for the patient or their families, as well as inefficient care. All participants in the private sector voiced frustration around a lack of, or inconsistent direct communication back to them from public sector referrals made to medical specialists. When questioned why this may be, they stated the public sector administration did not acknowledge NPs as primary providers or carers: only general practitioners were recognised.

Some participants reported that current restrictions on the above activities disadvantaged patients and were anticompetitive. One NP in the private sector shared the experience of having to refer a non-Medicare card holding patient for medical termination of pregnancy to a health service that resulted in substantial out-of-pocked costs for the patient. A medical termination of pregnancy is a safe, non-surgical approach to ending a pregnancy that involves the prescription of MS2Step (a medicine containing the abortifacient RU486) before 9 weeks' gestation. Instead, the NP could have safely performed the medical termination and not only reduced her inconvenience and shame, but could have achieved significant cost and time savings for the patient.

All participants reported that continuing professional development activities would be required to ensure any legislative, safety and/or policy issues relating to the above activities were correctly followed, and that the public were protected against harm. They felt this could be done through existing mechanisms that regulate the nursing profession, as well as guidance documents and education activities organised by the jurisdiction and/or professional bodies.

Common barriers to practice seen as relating to core NP activities were reflected in the participant interviews. An inability of NPs to initiate comprehensive diagnostic pathology, imaging, or specialist review that was reflective of the NP's individual scope of practice was a common theme amongst public sector NPs. It was also reflective of their inability to obtain a provider number or supportive policies and funding mechanisms to enable such activities. For example, in the public sector NP access to diagnostic imaging is very limited, and in all cases require authorisation by a medical practitioner or standing policy. In contrast, the inability to initiate imaging was a less common theme amongst private sector NPs, who could autonomously request any X-ray or ultrasound subsidised by the MBS. However, they experienced difficulties in requesting a comprehensive array of X-rays and ultrasounds, as well as advanced imaging studies (e.g. CT Scans, MRIs, DEXA Scans). This was because such exams were not subsidised by the MBS when requested by an NP. Although within their scope of practice and authorised to do so, requesting such exams would result in higher out-of-pocket costs for the patient. In this instance many private sector NPs would either provide financial consent resulting in higher patient out-of-pocket costs or such exams would be referred to a medical practitioner so the exam could be subsidised. Both public and private sector NPs cited the inability to initiate subsidised allied health referrals as a significant barrier to holistic and comprehensive patient care.

Many NPs in both the public and private sectors voiced concern around a lack of access to patient subsidies when prescribing medicines within their scope of practice through the Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS). Many medicines within the NP's scope of practice were not subsidised by the PBS/RPBS when prescribed, even though those medicines were subsidised when prescribed by a medical practitioner. In the management of many long-term health conditions, the PBS/RPBS required the NP to have many medicines prescribed initially by a medical practitioner before it would be subsidised with NP prescription. Several NPs stated in such circumstances they would then either prescribe the medicine privately or refer the patient to a medical practitioner for the initial prescription. In both instances out-of-pocket costs were increased for the health consumer when seeking care from an NP, and placed them at a disadvantage due to unaccumulated safety-net costs or through duplicated care pathways. In some instances, it was not clear if the patient chose to *not* fill the prescription to

have their condition properly managed because of the costs or pathways involved for obtaining medicine after being seen by an NP.

Some NPs working in the public sector voiced concern around the inflexible barriers surrounding a health service's model of care, which didn't properly account for the true NP scope of practice, and lacked support in NPs interpreting the "grey areas" in that model. Those NPs were concerned that if they took the initiative and worked within those grey areas they would be "stepping on toes" politically or with medical colleagues. When NPs chose to take the initiative and provide care within their individual scope of practice in the interests of the patient, efficiency and cost minimisation, they felt heavily scrutinised by their nursing colleagues and management. Others stated that, even when working within an established model of care, significant NP clinical practice decisions that prioritised patient and family choice would be undermined by medical practitioners in the community who felt the patient was "theirs", as opposed to a mutual collaboration required for the best interests of the patient. Those NPs acknowledged this wasn't typically an issue for those medical practitioners who were familiar with NPs and trusted the NP's decision-making. Others voiced confidence, not knowledge or ability, as being a barrier to these issues that would be best served by mentorship, activities and policies that promoted collaborative practice.

Several NPs in the public sector voiced concern that as they grew within their roles they had greater professional requirements for teaching, leadership, serving on committees and researching, which were not accounted for or supported in the same manner as their medical colleagues. Their expertise was felt to be discounted by management and they constantly had to "seek excessive permission and jump through additional hoops" to contribute professionally, even though such activities formed part of their endorsement standards. Participants suggested this could be remedied by supporting co-joint academic appointments and ensuring time and recurring education funding is quarantined for these purposes. Interestingly, private sector NPs did not appear to voice these same concerns as they either owned their own businesses or were supported by their organisations to undertake such activities in their own time. Public sector NPs voiced frustration over being supported through their academic NP programmes only to find there was no NP position for them once achieving endorsement. They suggested a strategic plan on how the NP workforce is implemented and integrated into the larger workforce, as well as the use of transitional NP positions, may be helpful in addressing this issue.

Finally, respondents were asked about the use of credentialing across both the public and private sectors in the ACT. Most private sector NPs were strongly against this notion because they could not see any additional benefit to themselves or their patients. Some private sector participants suggested that if they were required to undergo credentialing without a clear benefit to themselves or their patients, they would invoice the ACT Government for associated costs for time lost in preparing for the process. Others in the private sector were more circumspect and viewed the credentialing process as a means of gaining visitation rights for their patients in ACT public hospitals, akin to general practitioners. Many in the private sector described difficulties in legitimising their roles with public sector specialists, and viewed the credentialing process as one means of legitimisation and facilitation of patient care with those specialists.

Many public sector NPs voiced frustration with evolving credentialing processes and a lack of transparency in decision-making. Most felt it was a "tick and flick" exercise that did not translate to any real benefit to the NP, their individual scope of practice, or their patients. However, all public sector NPs acknowledged the need for credentialing as a requirement for hospital accreditation. Some public sector NPs working in community settings felt admission and discharge privileges would be helpful for their patients, although these were in the minority. They stated current credentialing process did not support admission or discharge privileges, as with medical practitioners.

# Manager, Supervisor and Employer Responses

Of the eligible survey participants who were managers, supervisors or NP employers, 100% (n=4) worked in the public sector and all completed the survey. When asked about their work setting, two respondents reported they worked in a public hospital setting, and two in a community setting.

With respects to the development of the NP role in their health services, all stated they had involvement (somewhat or very involved) in the introduction of the NP role. Half were either not involved (minimal or no involvement) or involved (somewhat or very involved) with the daily clinical work of NPs. Three out of four survey participants were nurses themselves.

Participants were asked to rate their agreement on a 5-point Likert scale (Strongly Disagree [1] – Strongly Agree [5]) with the statements presented in *Table 7* below:

*Table 6: Nurse practitioner employer, manager or supervisor perceptions*

| | **Public Sector** (n=4) |
|---|---|
| | **Weighted Ave.** (Max 5) |
| NP prescribing is necessary. | 4.67 |
| NPs offer holistic care. | 4.67 |
| NPs offer safe care. | 4.67 |
| The NP has a positive impact on patient care. | 4.67 |
| The NP role results in improved health service for patients. | 4.67 |
| NP practice is safe. | 4.67 |
| The NP uses an organised and systematic approach to history taking. | 4.67 |
| I fully understand the NP role. | 4.33 |
| Overall, the introduction of NP services has been a success. | 4.33 |
| NP service meets the needs of patients. | 4.33 |
| I trust the NP to diagnose correctly. | 4.33 |
| The NP service is easy to access. | 4.33 |
| The introduction of the NP has reduced delays in patient care. | 4.33 |

| | |
|---|---|
| NPs are adequately educated and prepared for their role. | 4.00 |
| The introduction of the NP has increased patient satisfaction levels. | 4.00 |
| The NP service enhances patient compliance with treatment. | 4.00 |
| NPs can refer patients directly to medical specialists. | 3.67 |
| The NP has access to a second opinion from medical colleagues when necessary. | 3.67 |
| The introduction of the NP has reduced duplication of service. | 3.67 |
| The introduction of the NP has reduced the number of health care professionals a patient must interact with. | 3.67 |
| The introduction of the NP has had a positive impact on inter-professional relationships. | 3.67 |
| The introduction of the NP has freed up doctors' time. | 3.33 |
| NPs are supported by doctors in their role. | 3.33 |
| I fear NPs will make an incorrect diagnosis. | 2.00 |
| NP prescribing increases the risk of incorrect treatment. | 1.33 |
| I am worried that NPs do not have the necessary knowledge to prescribe. | 1.33 |

When asked if they had any other comments they would like to make about the NP role, one participant responded. They indicated the lack of provider numbers in public services meant that NPs couldn't request diagnostic exams or make referrals without sign off by a doctor, and requested review to better support the NP role.

One participant requested to be interviewed at the conclusion of the survey. Overall, participants reported that the survey was representative of their views. Participants were then advised on the aims of the NP-PP in achieving "right touch" legislation and policy to enable NP practice. They were specifically requested to comment on the unintended consequences of facilitating the ability of NPs in the ACT to authorise/perform:

- death certificates and advance care directives
- worker's compensation and Comcare certificates
- driver's license medicals
- medical terminations of pregnancy

The participant did not comment on most aspects of the project, but did feel the issues surrounding worker's compensation was of particular importance. They did not support a model of NP care that acutely manages a work-related injury, but requires the provision of a worker's compensation certificate for that injury by the person's primary healthcare provider. They felt the initial certificate should be given by the NP treating the injury, and if follow up required, could then be followed by the person's primary healthcare provider.

# Discussion

This survey achieved its aim in gaining insight into the NP workforce in the ACT. It provided valuable perspectives into the barriers and potential solutions to the NP role across both the public and private sectors, and provided validation to proceed with the proposed intent of the NP-PP. To the author's knowledge, this is the first Australian survey to provide direct comparisons of practice and policy considerations between the NP workforce in the public and private health sectors.

In both the public and private health sectors, NPs have ongoing issues in fulfilling core activities of their role to their full scope of practice; namely: prescribing medicines, requesting diagnostic tests and initiating requests for medical specialist and allied health review. The survey data indicate NPs rate these activities as highly important to their roles. This is consistent with many of the barriers encountered by the Australian NP workforce that have been thoroughly described in the peer-reviewed and grey literature (Currie et al., 2019; Helms et al., 2015; Nurse Practitioner Reference Group, 2018; Smith et al., 2019).

However, what is not evident in the literature is the differences in barriers experienced by public and private sector NPs in completing core activities of their roles. Findings from this survey suggest that NPs in the private sector experience fewer barriers when initiating referrals to medical specialists. Additionally, there appear to be marginally fewer barriers in requesting diagnostic pathology when compared to the public sector. This finding was somewhat surprising given NPs have the same level of access to subsidised diagnostic pathology in the private sector as general practitioners (Australian Government, 2018). It is likely this finding is reflective of limited private sector NP understanding of MBS funding, individual scope of practice, or their employed role. Interview data from public sector NPs indicate they can only request limited diagnostic pathology through protocols with limited funding mechanisms, or under the provider number of an identified medical practitioner. Dependence upon the medical profession to undertake core activities of the NP role is at odds with the nursing regulator's statement that NPs are *independent* practitioners, not solely autonomous and collaborative health professionals (Nursing and Midwifery Board of Australia, 2020a).

Survey data indicated that both public and private sector NPs experience the same barriers in requesting diagnostic imaging tests. However, analysis of interview data indicated that this limitation is somewhat less in the private sector. In the public sector NPs are not able to freely request diagnostic imaging because they lack provider numbers or allocated funding for such requests. They may only initiate diagnostic imaging through restrictive protocols with limited funding mechanisms, or under the provider number of a medical practitioner. In the private sector NPs appear to have less restriction on basic imaging tests, and are only really limited in their requests for comprehensive imaging tests because of concerns over cost-shifting the price of those tests to health consumers. A review of the ACT legislation reveals the *Radiation Protection Act 2006* does not directly limit the scope of diagnostic imaging an NP may request.

Although there are many common tools and resources that NPs consider important (including their core activities) for practice, there are notable differences between health sectors. Access to the My Health Record, Australian Immunisation Register, and the ability to authorise advance care directives appear to hold more importance in the private sector than public sector NPs. Although survey data seem to indicate that authorising advance care plans and death certificates are less important tools,

interview data with individuals within both the public and private sectors indicate the ability to authorise advance care plans, as well as death certificates, is very important. Likewise, the ability to admit, discharge or hold visitation privileges within the public hospital system did not appear to be an important tool for many NPs in either health sector currently, although interview data with individuals suggested future practice models could evolve to use such tools if enabled for the workforce. These findings are likely reflective of a heterogenous sample of NPs working within the public and private sectors and the diverse models of care in which they work.

There appears to be important differences in organisational culture between private and public sector NPs in the ACT, with the private sector perceived as being more favourable to practice by NP participants. The private sector appears to make greater efforts in improving working conditions, resulting in NPs feeling valued by their organisations. Likewise, it appears NPs and doctors are given similar support for care management, and information and resources appear to be shared more equitably in the private sector. There also appears to be improved communication amongst the executive team and NP clinicians. None of these findings are entirely surprising given the private sector is generally represented by smaller organisations, typically have more amenable working hours, and have smaller work units resulting in direct reporting lines. An Australian study recently conducted with a small sample of NPs practising across Australia examining organisational culture appears to have similar findings to those in the private sector, although direct comparisons are difficult as they did not provide this level of analysis (Scanlon et al., 2018). Interestingly, survey data from NP employers, managers and supervisors in the public sector suggest a discrepancy between the high value they place on the NP workforce, and how public sector NPs themselves perceive their value. This finding likely reflects issues surrounding communication and merit further exploration.

Finally, survey and interview data show that significant practice barriers, and potentially organisational culture, are important factors contributing to NP workforce clinical efficiency in the ACT. There appears to be fewer practice barriers and improved organisational culture for NPs practising in the private sector given the survey data and interview results, which likely aids clinical efficiency. Clinical efficiency ultimately translates to outcomes, of which NP participants indicate that data measuring PROMs and PREMs would be most helpful in measuring their value. Despite the utility of such outcomes measures in value-based healthcare (Porter & Lee, 2013), they appear to be highly underutilised in both health sectors, but especially so in the private sector. This is likely reflective of a lack of funding support to undertake such activities in the private sector. Enterprise bargaining agreements and funding mechanisms in the public sector generally better support such activities on an individual or service-level basis.

Ultimately, the survey and interview results appear to be reflective of the differences between NP *scope of practice* issues and the role's *practice authority*. Scope of practice entails what activities the *individual* practitioner is authorised by legislation to perform, and is *competent* to do. Practice authority is a broader construct, and reflective of what a *profession or role* is legislatively authorised to do (American Association of Nurse Practitioners, 2021; Hudspeth & Klein, 2019; Nurse Practitioner Schools, 2020). As individual NPs and their employers are already accountable for NPs competently practising within their individual scope of practice, it is perhaps important to consider the role of 'right touch' legislation in allowing the independent role of the NP in achieving full practice authority.

# Strengths and Limitations

Overall, this online survey had strong representation from the current NP workforce in the ACT. The survey had an excellent NP response and completion rate, compared to many online surveys (Helms et al., 2017). This survey provides a unique perspective in the differences seen in NP practice in the ACT across both the public and private health sectors.

Unfortunately, NP workforce employers, managers and supervisors were under-represented in this study. It is uncertain why this might be, but this should be accounted for in future consultations to ensure public and employer contributions are seen in the outcomes of the NP-PP. Given the sample of NPs were recruited from databases in both the public sector and through the ACNP, it is likely private sector NPs were under-represented in this sample.

The lens used by the author in this report lends both strengths and limitations. It has been influenced by the author's extensive experience working across both the public and private health sectors as a NP.

# Conclusion

The survey and interview data from this project provided valuable insights into the current NP workforce in the ACT, across both the public and private sectors. It provided clarity the NP-PP is about achieving full practice authority for the existing NP workforce, and not necessarily individual scope of practice. It identified there are ongoing significant barriers to the core activities of the NP role that impact upon clinical efficiency. It appears these barriers can be effectively addressed through strategy development, as well as legislation and policy reform.

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# Appendix A: Nurse Practitioner and Workforce Survey

ACT Nurse Practitioner Workforce and Employer Survey

Introduction

**Welcome to the ACT Nurse Practitioner (NP) Workforce and Employer Survey! This survey informs part of the Nurse Practitioner Professional Scope of Practice Project (NPPSPP), which is sponsored by the ACT Office of the Chief Nursing and Midwifery Officer.**

**The NPPSPP aims to provide expert advice that shapes "right touch" legislation and strategic policy, which enables NPs working in the Australian Capital Territory (ACT) to safely and effectively work to their full scope of clinical practice. It is anticipated that outcomes from this project will affect NP workforce strategy across both the public and private health sectors.**

**This survey aims to better understand the following:**

- **Current NP workforce characteristics and practice profiles;**
- **How employers use and their perceptions of the NP workforce; and**
- **Barriers and facilitators to NP practice.**

**Data from this survey will be used to inform a broader stakeholder consultation strategy.**

**Important Information:**

- **This survey will close on 23 December 2020 @ 5PM;**
- **This survey is open to endorsed NPs, student NPs and their employers/managers who work within the ACT;**
- **Your responses are confidential and data will be aggregated to ensure anonymity;**
- **If you have any questions or concerns regarding this survey please contact:**
  - **Chris Helms, Senior Project Adviser**
  - **ACT Health Directorate**
  - **Office of Professional Leadership and Education**
  - **E: christopher.helms@act.gov.au**
  - **T: 02 5124 9545**

**This survey will take approximately 10-15 minutes of your time. Please find a comfortable and quiet time to complete at your convenience.**

**By clicking the "Next" button below you consent to participating in this survey:**

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## ACT Nurse Practitioner Workforce and Employer Survey

### Eligibility Criteria

* 1. Do you **work** in the Australian Capital Territory or surrounds (e.g. Queanbeyan)?

- Yes
- No

* 2. What **perspective** best describes your views in this survey?

- NMBA-Endorsed Nurse Practitioner (NP)
- NP Employer/Manager
- Student Nurse Practitioner
- Other

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## ACT Nurse Practitioner Workforce and Employer Survey

### Student Nurse Practitioners

**You have stated that your views represent those of a student nurse practitioner.**

* 3. Are you currently enrolled in a Master of Nurse Practitioner academic program?

- Yes
- No

* 4. What best describes your current employment status?

- Employed, Full-Time
- Employed, Part-Time
- Casual Worker
- Contractor
- Other (please specify)

* 5. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

* 6. What best describes your current role?

- Clinician
- Administrator
- Teacher or educator
- Researcher

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* 7. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force
- Other (please specify)

8. What is your *specific* specialty area in which you are seeking endorsement?

* 9. How many more years do you intend to remain in the nursing workforce?

* 10. Do you currently work with an endorsed NP?

- Yes
- No

* 11. Do you currently have an NP mentor or supervisor that is helping you develop into the NP role?

- Yes
- No

* 12. What year do you expect to seek endorsement as an NP?

* 13. In my organisation, the NP role is well understood.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| | | | | |

* 14. My manager is well informed of the skills and competencies of NPs.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| | | | | |

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* 15. I feel valued by my organisation.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 16. I regularly get feedback about my performance from my organisation.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 17. Doctors in my practice setting trust my patient care decisions.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 18. In my organisation, I freely apply all my knowledge and skills to provide patient care.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 19. My organisation inappropriately restricts my abilities to practice within my scope of practice.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 20. My organisation creates an environment where I can practice autonomously.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

21. Please enter your details below if you would like to be interviewed about your survey responses:

**Name**

**Email Address**

**Phone Number**

22. Do you have any further comments?

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## ACT Nurse Practitioner Workforce and Employer Survey

### Nurse Practitioner Demographic Data - 1

**You have stated that your views represent those of an NP endorsed by the Nursing and Midwifery Board of Australia.**

* 23. What best describes your current employment status?

- ◯ Employed, Full-Time
- ◯ Employed, Part-Time
- ◯ Casual Worker
- ◯ Retired
- ◯ Contractor
- ◯ Unemployed

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## ACT Nurse Practitioner Workforce and Employer Survey

### Nurse Practitioners Workforce

* 24. Are you currently working in a role requiring you to be a nurse practitioner?

- Yes
- No

* 25. What best describes your current role?

- Clinician
- Administrator
- Teacher or educator
- Researcher

* 26. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Other (please specify)
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force

* 27. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

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* 28. Which metaspecialty(ies) is/are most representative of your clinical practice?

*You may select one or more metaspecialty areas.*

- [ ] Primary Healthcare
- [ ] Mental Healthcare
- [ ] Emergency and Acute Care
- [ ] Child and Family Health Care
- [ ] Ageing and Palliative Care
- [ ] Chronic and Complex Care

29. If relevant, what specific specialty area do you work in?

*For example: cardiology, wound care, emergency fast-track, etc.*

* 30. How many years have you been endorsed as an NP in Australia?

* 31. How many more years do you intend to remain in the nursing workforce?

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## ACT Nurse Practitioner Workforce and Employer Survey

### Nurse Practitioners Not Working in Clinical Practice

* 32. You have indicated that you are not currently working in clinical role or a position requiring you to be a nurse practitioner. Why?

*Please choose the most relevant reason.*

- Family obligations.
- Retired (or nearing).
- Insufficient remuneration for role.
- Lack confidence to practice.
- Lack employer support for role.
- Current scope of practice does not align with available NP jobs.
- Current position doesn't require clinical practice.
- Personal health-related reason.
- Personal preference.
- Greater opportunity for advancement.
- Other (please specify)

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## ACT Nurse Practitioner Workforce and Employer Survey

### Organisational Climate

**In this next section, we would like you to describe your current organisational climate.**

* 33. In my organisation, the NP role is well understood.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 34. My manager is well informed of the skills and competencies of NPs.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 35. I feel valued by my organisation.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 36. I regularly get feedback about my performance from my organisation.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 37. The organisation is open to NP ideas to improve patient care.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 38. My manager takes NP concerns seriously.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 39. The organisation shares information and resources equally with NPs and doctors.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 40. The organisation makes efforts to improve working conditions for NPs.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 41. In my organisation, there is constant communication between NPs and the executive team.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 42. I feel valued by my medical colleagues.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 43. Doctors seek NPs' advice and input when providing patient care.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 44. Doctors in my practice setting trust and support my patient care decisions.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 45. In my practice setting, I have colleagues who I can ask for help.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 46. NPs are an integral part of the organisation.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 47. I do not have to discuss every patient care detail with a doctor.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 48. In my organization, I freely apply all my knowledge and skills to provide patient care.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

* 49. My organisation inappropriately restricts my abilities to practice within my scope of practice.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ |

* 50. Doctors and NPs have similar support for care management (e.g. help with patient follow-up, referrals, labs, etc.).

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ |

* 51. My organisation creates an environment where I can practice independently and collaboratively.

| Strongly Disagree | Disagree | Neither Disagree or Agree | Agree | Strongly Agree |
|---|---|---|---|---|
| ◯ | ◯ | ◯ | ◯ | ◯ |

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## ACT Nurse Practitioner Workforce and Employer Survey

### Safe, Effective, and Efficient Care

**In this section, you will be asked about significant enablers and barriers to NP clinical practice.**

* 52. There are tools and resources that NPs need in order to do their clinical work *safely, effectively and efficiently.*

Rank the importance of the following tools and resources to your **current and future** NP role:

| | Not Important | Somewhat Important | Important | Very Important |
|---|---|---|---|---|
| Prescribe subsidised medicines. | ○ | ○ | ○ | ○ |
| Request subsidised medical specialist review. | ○ | ○ | ○ | ○ |
| Request subsidised diagnostic pathology. | ○ | ○ | ○ | ○ |
| Request subsidised allied health review. | ○ | ○ | ○ | ○ |
| Request subsidised diagnostic imaging. | ○ | ○ | ○ | ○ |
| Clinical documentation and support software. | ○ | ○ | ○ | ○ |
| Access to the My Health Record. | ○ | ○ | ○ | ○ |
| Access to the Australian Immunisation Register. | ○ | ○ | ○ | ○ |
| Clerical support. | ○ | ○ | ○ | ○ |
| Hospital admission privileges. | ○ | ○ | ○ | ○ |
| Hospital discharge privileges. | ○ | ○ | ○ | ○ |
| Hospital visitation privileges. | ○ | ○ | ○ | ○ |
| Ability to sign death certificates. | ○ | ○ | ○ | ○ |

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| | Not Important | Somewhat Important | Important | Very Important |
|---|---|---|---|---|
| Ability to sign worker's compensation/worksafe certificates. | ◯ | ◯ | ◯ | ◯ |
| Ability to sign advance care directives. | ◯ | ◯ | ◯ | ◯ |
| Ability to sign driver's license medicals. | ◯ | ◯ | ◯ | ◯ |
| Access to prescribing support software (e.g. eTG Complete, Micromedex). | ◯ | ◯ | ◯ | ◯ |
| Access to the Australian Immunisation Handbook. | ◯ | ◯ | ◯ | ◯ |
| Access to Australian Medicines Handbook or similar (e.g. MIMS). | ◯ | ◯ | ◯ | ◯ |
| Access to online databases (e.g. UpToDate Online, NICE Guidelines, CINAHL, etc.). | ◯ | ◯ | ◯ | ◯ |
| Access to peer review of patient care. | ◯ | ◯ | ◯ | ◯ |
| Access to mentorship. | ◯ | ◯ | ◯ | ◯ |
| Access to portable technology (e.g. mobile phones, laptops, diagnostic equipment). | ◯ | ◯ | ◯ | ◯ |

* 53. Clinical efficiency is simply defined as *clinical outcome* divided by *time*. For example, the time taken to assess, diagnose and treat an un-displaced minor fracture, hypothyroidism, or dementia.

Importantly, clinical efficiency also encompasses administrative processes that result in care outcomes, such as documenting care, filling out forms, requesting screening and diagnostic testing, prescribing, and referring to other health professionals.

As indicated in the previous question, there are certain tools NPs require for clinically-efficient care.

**Do you have all the tools and resources you require for clinically-efficient care?**

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

If desired, please expand upon your response:

* 54. Are you able to prescribe medicines to your full scope of practice?

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

* 55. Are you able to request diagnostic pathology (e.g. blood tests, histology, etc.) to your full scope of practice?

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

* 56. Are you able to freely refer to medical specialists within your full scope of practice?

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

* 57. Are you able to freely refer to allied health specialists within your full scope of practice?

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

* 58. Are you able to request diagnostic imaging (e.g. X-rays, CT-Scans, Ultrasounds) to your full scope of practice?

| Not At All | Somewhat | Mostly | Yes, Absolutely |
|---|---|---|---|
| ○ | ○ | ○ | ○ |

59. When thinking about outcomes of NP-directed care, we might think of many different types of measures to identify success or areas for improvement.

*What are specific measures of success that you believe are helpful in identifying the "value add" of NP clinical practice?*

- ☐ Patient-reported **outcomes** measures (PROMs)
- ☐ Patient-reported **experience** measures (PREMs)
- ☐ Length of Stay
- ☐ Biometric Measures (e.g. HbA1c, Blood Pressure, Weight, etc.)
- ☐ Financial Measures (e.g. income generated)
- ☐ Activity Measures (e.g. number of clients seen, procedures performed, etc.)
- ☐ Hospital re-admissions
- ☐ Other (please specify)

60. Are the measures you've identified monitored and reported by your health service?

| Never | Rarely | Sometimes | Usually | Always |
|---|---|---|---|---|
| ○ | ○ | ○ | ○ | ○ |

61. Do you have any further comments?

62. Please enter your details below if you would like to interviewed about your survey responses:

**Name**

**Email Address**

**Phone Number**

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ACT Government Health

## ACT Nurse Practitioner Workforce and Employer Survey

### Employer Demographic Data

**You have stated your views in this survey are reflective of an employer or manager of nurse practitioners.**

* 63. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

* 64. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Other (please specify)
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force

* 65. Please choose the best descriptor for your role:

- Executive
- Manager
- Director
- Other (please specify)

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* 66. Please indicate your level of involvement in:

| | No Involvement | Minimal Involvement | Somewhat Involved | Very Involved |
|---|---|---|---|---|
| The introduction of the NP role. | ○ | ○ | ○ | ○ |
| The daily clinical work of the NP. | ○ | ○ | ○ | ○ |

* 67. Please indicate your profession:

- ○ Aboriginal and/or Torres Strait Health Practitioner
- ○ Chinese Medicine Practitioner
- ○ Chiropractor
- ○ Dental Practitioner
- ○ Medical Practitioner
- ○ Medical Radiation Practitioner
- ○ Nurse
- ○ Midwife
- ○ Occupational Therapist
- ○ Optometrist
- ○ Paramedic
- ○ Pharmacist
- ○ Physiotherapist
- ○ Podiatrist
- ○ Psychologist
- ○ Other (please specify)

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ACT Government Health

## ACT Nurse Practitioner Workforce and Employer Survey

### Perceptions of Nurse Practitioner Service

**These questions are designed to elicit your views on the NP role. In responding to the items please draw upon your current experience of working with a nurse practitioner.**

* 68. Please read and rate each statement:

| | Strongly Disagree | Disagree | No Opinion | Agree | Strongly Agree |
|---|---|---|---|---|---|
| I fully understand the NP role. | ◯ | ◯ | ◯ | ◯ | ◯ |
| Overall the introduction of NP services has been a success. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NP service meets the needs of the patients. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NP prescribing increases the risk of incorrect treatment. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NP prescribing is necessary. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NPs offer holistic care. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NPs offer safe care. | ◯ | ◯ | ◯ | ◯ | ◯ |
| I trust the NP to diagnose correctly. | ◯ | ◯ | ◯ | ◯ | ◯ |
| I am worried that NPs do not have the necessary knowledge to prescribe. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The NP service is easy to access. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The NP has a positive impact on patient care. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NPs are adequately educated and prepared for their role. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NPs can refer patients directly to medical specialists. | ◯ | ◯ | ◯ | ◯ | ◯ |

| | Strongly Disagree | Disagree | No Opinion | Agree | Strongly Agree |
|---|---|---|---|---|---|
| The NP has access to a second opinion from medical colleagues when necessary. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The NP role results in improved health service for patients. | ◯ | ◯ | ◯ | ◯ | ◯ |
| I fear NPs will make an incorrect diagnosis. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has reduced delays in patient care. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has reduced duplication of service. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has reduced the number of health care professionals a patient must interact with. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has increased patient satisfaction levels. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has freed up doctors' time. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The introduction of the NP has had a positive impact on inter-professional relationships. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The NP service enhances patient compliance with treatment. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NP practice is safe. | ◯ | ◯ | ◯ | ◯ | ◯ |
| The NP uses an organised and systematic approach to history taking. | ◯ | ◯ | ◯ | ◯ | ◯ |
| NPs are supported by doctors in their role. | ◯ | ◯ | ◯ | ◯ | ◯ |

69. Do you have any other comments about the NP role?

70. Please enter your details below if you would like to interviewed about your survey responses or NPs generally:

**Name**

**Email Address**

**Phone Number**

# Appendix B: Survey Invitation Email

OFFICIAL

Dear Stakeholder –

The ACT Office of the Chief Nurse and Midwifery Officer invites you to take part in an important **nurse practitioner workforce and employer** survey. This survey will provide key information for targeted stakeholder consultation strategies planned in the ACT during January 2021.

The online survey will take approximately 10-15 minutes of your time, and is intended for:

- Endorsed Nurse Practitioners;
- Student Nurse Practitioners; and
- Nurse Practitioner Employers

**Feel free to forward this email and survey link to those you think may want to take this survey** or that you think may have missed out on this email.

To access the survey, please click HERE.
Alternatively, you can copy and paste this hyperlink into your web-browser:
https://www.surveymonkey.com/r/ACT_NPSurvey

Surveys will close on **23 December 2020 at 5PM**. Please fill yours out today!

If you have any questions or concerns regarding this survey or project, please feel free to contact:
Chris Helms, Senior Project Adviser
ACT Health Directorate
Office of Professional Leadership and Education
E: Christopher.Helms@act.gov.au
T: 02 5124 9545

Kind Regards,
Chris Helms
*On Behalf of the ACT Chief Nursing and Midwifery Officer, Anthony Dombkins*

**Chris Helms, Senior Project Adviser**
Ph: 02 5124 6262 | Email: christopher.helms@act.gov.au
**Nursing and Midwifery Office | ACT Health Directorate**
Level 3, 2-6 Bowes Street Phillip ACT 2606
health.act.gov.au
Working Days: Wednesdays - Fridays

# Appendix C: Interview Questions

1. Thank you for taking the time to meet and discuss your survey. Please tell me about your survey experience.
    a. Why did you choose to be interviewed today? Did you find the survey representative of your views?
2. This project aims to look at the barriers to nurse practitioner (NP) full practice authority (scope of practice). It aims to provide recommendations for "right touch" legislation and policy that enables NP practice.
    a. Please tell me about any barriers you experience and how you see these could be resolved.
    b. What are the potential unintended consequences of allowing nurse practitioners working within their scope of practice to authorise the following:
        i. Death Certificates;
        ii. Advance Care Directives;
        iii. Worker's Compensation Certificates;
        iv. ComCare Certificates; and
        v. Driver's License Medicals
    c. What frameworks, education and/or support would be required to demonstrate to ensure nurse practitioners could perform the above activities safely and effectively?
    d. Should a credentialing framework be used for nurse practitioners across both the public and private sectors? Why or why not?
    e. What are the advantages and unintended consequences of creating transitional NP positions in the public sector?
    f. What frameworks, education and/or support would be required for a nurse practitioner working within their scope of practice to perform a medical termination of pregnancy?
    g. Do you have any further comments or concerns?